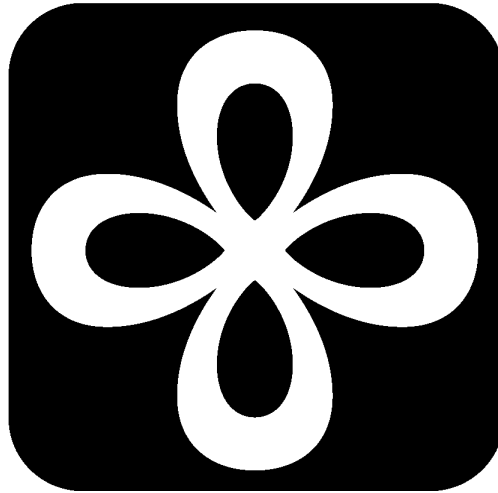


**STATE OF IOWA
DEPARTMENT OF HUMAN SERVICES**

MEDICAID



Provider Manual

Community Mental Health Center




CHAPTER E. COVERAGE AND LIMITATIONS

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I. CENTERS ELIGIBLE TO PARTICIPATE

Community mental health centers (CMHCs) are eligible to participate in the Medicaid program providing they are in compliance with the community mental health center standards established by the Department of Human Services, Division of Behavioral, Developmental and Protective Services for Families, Adults and Children (BDPS).

In order for CMHCs to participate in the Medicaid day treatment programs for adults or children, they must additionally be certified for each program by the Division of BDPS.

II. COVERAGE OF SERVICES

Payment will be approved for all reasonable and necessary services provided by a psychiatrist or by a psychologist on the staff of a CMHC without other supervision who is on, or meets the requirements of, the National Register of Health Service Providers in Psychology.

Each CMHC must submit the names of those psychologists who meet the requirements of the National Register to the fiscal agent and obtain approval before billing their services. The CMHC must show the psychologist's name and discipline in the description of service on each of the psychologist's services claimed.

A. Conditions of Payment

Payment will be approved for services provided by other psychologists, social workers, or psychiatric nurses on the staff of the center, subject to the following conditions:

1. Each patient must have an initial evaluation. This includes at least one personal evaluation interview with a mental health professional, as defined under Iowa Code, Section 228.1. The evaluation interview must be completed before the submission of the first claim for services rendered to that patient.

If the evaluation interview results indicate a need for a referral for an interview with a board-eligible or board-certified psychiatrist, then such referral shall be made.



Exception: A preliminary diagnostic evaluation of a recipient for voluntary admission to one of the state mental health institutes is payable without the psychiatric personal interview or staffing requirements.

2. Pursuant to 441 Iowa Administrative Code 78.16(1)“b”(2), the peer review process in place for the CMHC shall be used for the purposes of providing ongoing review and assessment of the patient.

The peer review process shall involve all necessary professional staff of the CMHC involved in direct service delivery and supervision thereof, as specified or otherwise defined in the CMHC’s peer review process.

Results of the peer review process and information collected as a result thereof relative to a given patient shall be recorded and placed in the patient’s record, as appropriate and necessary and placed in the patient’s permanent record.

3. Consistent with item “2” above, there must be regular and ongoing review and assessment of the patient’s treatment needs, treatment plans, and the appropriateness of services rendered.

This ongoing review and assessment must be conducted by appropriate staff, as required by the peer review process specified under 441 Iowa Administrative Code 78.16(1)“b”(2).

The treatment plans for and services rendered to patients of the CMHC shall be evaluated and revised as necessary and appropriate, consistent with the CMHC’s peer review process.

4. Regular and ongoing reviews under the peer review process, described in items “2” and “3” above, are not payable as separate services. The CMHC must maintain the results of and information related to the peer review process. These records are subject to review and audit by the Department of Human Services, its Medicaid fiscal agent, or other Department designees.
5. Clinical records of Medicaid patients shall be available to the fiscal agent on request. All such records shall be held confidential.




6. Coverage of services provided by staff of the center, including adult or children day treatment services, is limited to services provided on-site of the CMHC or in a satellite office of a CMHC. Exception: Day treatment program services may include off-premise activities when the activity is therapeutic and is integrated into the day treatment program's description and milieu plan.

Each CMHC shall provide and update the fiscal agent with the current address of the CMHC and any satellite offices. For Medicaid purposes, to be considered a satellite office of an accredited CMHC, an office must meet the following conditions:

- a. The services provided in the satellite office must be accessible to all persons in the center's service area.
- b. The location and hours of the satellite office must be made available to the public.
- c. The board of the CMHC must officially recognize the location as a satellite office.

It is the responsibility of the CMHC to contact the fiscal agent and provide an update whenever there is a change of address, when a new satellite office is opened or an office closes.

If a psychiatrist on the staff of the CMHC provides service to a hospitalized recipient, the psychiatrist may bill the fiscal agent under the psychiatrist's own private practice provider number. If the psychiatrist wishes to submit claims under the private practice number and have the fiscal agent pay the CMHC, the provider number of the CMHC and the provider number of the physician must be entered in the appropriate area of the claim form. See Chapter F for claim completion instructions.

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The psychiatrist must submit to the Provider Enrollment Unit of the fiscal agent a signed authorization allowing payment to be made directly to the CMHC.

This procedure is applicable only to the psychiatrist.

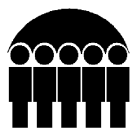
Psychiatric nurses, psychologists and social workers may render services under the supervision of the physician when following the staffing regulations. Services rendered on the premises of the CMHC or the satellite office do not require the presence of the physician.

7. The Health Care Financing Administration has preadmission screening and annual resident review (PASARR) requirements for nursing facilities. Persons entering a nursing facility are screened to determine if they have a need related to mental illness, mental retardation, or a related condition (developmental disability). This is a Level I screening. If the person has such needs, the Iowa Foundation for Medical Care requires a further evaluation by a psychologist or a CMHC before Medicaid will pay the nursing home care. This Level II evaluation shall specifically identify the needs of the resident, so that the facility can develop a plan to meet the resident's needs. These procedures may be provided in a nursing home.

B. Day Treatment for Adults

Payment to a CMHC will be approved for day treatment services for persons aged 21 or over if the center is certified by MH/MR/DD for day treatment services and the services are provided on the premises of the CMHC or a satellite office of the CMHC.

CMHCs with day treatment programs for persons aged 21 or over shall address:

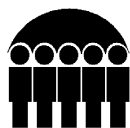


1. Documented need for day treatment services for adults in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.
2. Goals and objectives of the day treatment program for adults that meet the day treatment program guidelines noted below.
3. Organization and staffing, including how the day treatment program for adults fits with the rest of the CMHC, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employees, contractual, or consultant.
4. Policies and procedures for the program, including admission criteria, patient assessment, treatment plan, discharge plan, and postdischarge services, and the scope of services provided.
5. Any accreditations or other types of approvals from national or state organizations.
6. The program's physical facility and equipment.

Day treatment services for adults shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability, and psychosocial interactions, and training in medication management. Services are structured with an emphasis on program variation according to individual need.

Services shall meet the applicable criteria found in II.A, Conditions of Payment, to be payable by Medicaid.




Services may be provided for a period of three to five hours per day, three or four times per week.

Day treatment services provided for more than five sessions require individualized treatment plans. The treatment plan must state the type, amount, frequency, and duration of the service and the anticipated goals. The treatment plan shall be developed by a board-eligible or board-certified psychiatrist, a staff psychiatrist, or a psychologist meeting the requirements of the National Register of Health Service Providers in Psychology.

Day treatment is available to any Medicaid recipient aged 21 or over for whom the service is appropriate, that is, the service is reasonable and necessary for the treatment of the person's condition. It is likely that the primary users of the service will be persons with chronic mental illness, due to the nature of the service.

The Iowa Legislature has appropriated special funds to the Department for certain Medicaid services that will be used primarily by recipients with mental retardation, chronic mental illness, or a developmental disability. To ensure that funds are properly allocated, a CMHC which provides day treatment services to these Medicaid recipients shall report certain information to the Department. This includes information as to the diagnostic category applicable to the recipient and information concerning the recipient's legal settlement. (See Chapter F, III. Enhanced Services Reporting Form and Instructions.)

As day treatment programs for adults and children have different focuses, persons aged 18 through age 20 with chronic mental illness may be better served by the adult day treatment program. As a result, persons between the ages of 18 and 20 with chronic mental illness may access the day treatment program which best meets their needs, day treatment for adults or day treatment for children. (Note, however, that the county of legal settlement must be stated on the claim for day treatment for adults.)

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C. Day Treatment for Children

Payment to a CMHC will be approved for day treatment services for persons aged 20 or under if:

- ◆ The center is certified by the Department's Division of Mental Health and Developmental Disabilities for day treatment services.
- ◆ The services are provided on the premises of the CMHC or a satellite office of the CMHC.

Exception: Day treatment program services may include off-premise activities when the activity is therapeutic and is integrated into the day treatment program's description and milieu plan.

Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who are not inpatients in a medical institution or residents of a group care facility licensed under 441 IAC Chapter 114.


Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment hours may be gradually decreased as day treatment services transition to discharge of the patient from the program.

Persons aged 18 through age 20 with chronic mental illness may have varying needs. Access is available from the day treatment program which best meets their needs: day treatment for adults or day treatment for children.

Services shall meet the applicable criteria found in II.A, **Conditions of Payment**, to be payable by Medicaid.

CMHCs with day treatment programs for persons aged 20 or under shall address:

- ◆ Documented need for day treatment services for children in the area served by the program, including:
 - Studies.
 - Needs assessments.
 - Consultations with other health care professionals.
- ◆ Goals and objectives of the day treatment program for children that meet the guidelines below.

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- ◆ Organization and staffing, including:
 - How the day treatment program for children fits with the rest of the CMHC.
 - The number of staff.
 - Staff credentials.
 - The staff's relationship to the program, e.g., employees, contractual, or consultant.
- ◆ Policies and procedures for the program, including:
 - Admission criteria.
 - Patient assessment.
 - Treatment plan.
 - Discharge plan.
 - Postdischarge services.
 - The scope of services provided.
- ◆ Any accreditations or approvals from national or state organizations.
- ◆ The program's physical facility and equipment.

1. Program Requirements

Day treatment programs for persons aged 20 or under shall meet the following criteria:

- ◆ Staffing shall be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants.

Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio. "Professional" or "clinical" staff are those staff who are either mental health professionals as defined in 441 IAC 24.61(225C, 230A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional.

All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting



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staff or professional clinical staff) when engaged in administrative, clerical, or support activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio. Certified occupational and recreational therapy assistants are not countable in the staff-to-patient ratio.

- b. Staffing shall reflect how program continuity will be provided, and shall reflect an interdisciplinary team of professionals and paraprofessionals.
- c. Staffing shall include a designated director who is a mental health professional. The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.
- d. Staffing shall be provided by or under the general supervision of a mental health professional. When services are provided by an employee or consultant of the CMHC who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular and documented.

The employee or consultant shall have a minimum of a bachelor's degree in a human-services-related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Certified occupational and recreational therapy assistants are eligible to provide direct services under the general supervision of an occupational or recreational therapist and the mental health professional.

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- e. The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.
- f. Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented, along with a schedule of when service activities are available, including the days and hours of program availability.
- g. There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.
- h. The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with local school districts and educational cooperatives. Relationship with other entities, such as physicians, hospitals, private practitioners, halfway houses, the Department, the juvenile justice system, community support groups, and child advocacy groups are encouraged.

The provider's program description shall describe how community links will be established and maintained.

- i. Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

2. Programming

Day treatment services for children shall be a time-limited, goal-oriented,



active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu.

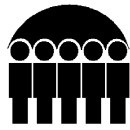
Time-limited means that the patient is not expected to need services indefinitely, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary.

Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family-focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family. At a minimum, day treatment services are expected to improve the patient's condition, restore the condition to the level of functioning before onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization.

Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive, and complimentary schedule of therapeutic activities, and shall have the capacity to treat a wide array of clinical conditions. The following services shall be available as components of the day treatment program:

- a. Psychotherapeutic treatment services (examples: individual, group, and family therapy).
- b. Psycho-social rehabilitation services. Active treatment examples include, but are not limited to, individual and group therapy;




medication evaluation and management; expressive therapies; theme groups, such as communication skills, assertiveness training, other forms of community skills training, or stress management; chemical dependency counseling, education, and prevention; symptom recognition and reduction; problem solving; relaxation techniques; and victimization (sexual, emotional, or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health.

Although these other services may be provided, they are not the primary focus of treatment.

- c. Evaluation services. Evaluation services shall determine need for day treatment before program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed.

Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services. This service must be completed by a mental health professional. An evaluation from another source performed within the previous 12 months may be substituted if there has not been a change. Medicaid will not make separate payment for these services under the day treatment program.

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d. Assessment Services

All day treatment patients shall receive a formal, comprehensive biopsychosocial assessment of day treatment needs. If applicable, include a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. Address in the assessment whether medical causes for the child's behavior have been ruled out.

An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same. If not, parts of the assessment which reflect current functioning may be used as an update.

Using the assessment, produce a comprehensive summation, including the findings of all assessments performed. Use the summary in forming a treatment plan, including treatment goals.

Also consider and consistently monitor indicators for discharge planning, including:

- ◆ Recommended follow-up goals.
- ◆ Provision for future services.

e. Educational Component

The day treatment program may include an educational component as an additional service. The patient's educational needs shall be served without conflict from the day treatment program.

Hours in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid. Example:



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The patient attends the day treatment program from 9:00 a.m. to 3:00 p.m.
The patient attends the educational component from 9:00 a.m. to noon.


The hours the patient attended the educational component are deducted from the day treatment hours. The billable day treatment hours for Medicaid are three hours. The day treatment program may wish to pursue funding of educational hours from local school districts.

These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

Exception: Individual or family therapy services received on days in which the patient does not attend day treatment can be separately billed.

This exception does not eliminate or reduce the need for individual, group, or family therapy to be an integral part of the active treatment programming. Such therapy shall be provided during at least 50% of the scheduled program hours. Rather, it provides additional therapies for persons in need of more intensive treatment. Example:

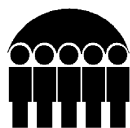
The patient attends the day treatment program on Monday, Wednesday and Friday. Additional individual therapy is provided on Tuesdays to deal with a specific issue that is not addressed by the day treatment program. The CMHC submits a separate claim for the Tuesday services.

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3. Admission Criteria

The admission criteria for day treatment for persons aged 20 or under are:

- ◆ The patient is at risk for exclusion from normative community activities or residence due to factors such as:
 - Behavioral disturbance.
 - Chemical dependence.
 - Depression.
- ◆ The patient exhibits one or more of the following:
 - Psychiatric symptoms.
 - Disturbances of conduct.
 - Decompensating conditions affecting mental health.
 - Severe developmental delays.
 - Psychological symptoms.
 - Chemical dependency issues.
- ◆ These symptoms are sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.
- ◆ Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate. This includes Individual or group therapy services provided by:
 - A physician in the physician's office.
 - Auxiliary staff of a physician in the physician's office.
 - A qualified mental health professional employed by a CMHC.
- ◆ The patient's principle caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, and to enable adequate control of the patient's behavior. The caretaker must be involved in the patient's treatment.



If the principle caretaker is unable or unwilling to participate in the provision of services, document how services will benefit the child without caretaker involvement. Services will be covered when the plan reflects reasonable opportunity for success. Persons who have reached majority, either by age or emancipation, are exempt from family therapy involvement.

- ◆ The patient has the capacity to benefit from the interventions provided.

Examples:

- A patient with mental retardation may not be appropriate for a day treatment program if the patient is unable to participate and benefit from group milieu therapy.
- A patient exhibiting acute psychiatric symptoms (e.g., hallucinations) may be too ill to participate in the day treatment program.

4. Individual Treatment Plan

Prepare a treatment plan for each patient receiving day treatment services. The treatment plan shall be developed or approved by one of the following:

- ◆ A board-eligible or board-certified psychiatrist.
- ◆ A staff psychiatrist.
- ◆ A physician.
- ◆ A psychologist registered on the National Register of Health Service Providers in Psychology or the Iowa national Register of Health Service Providers in Psychology.

Approval will be evidenced by a signature of the physician or health service provider in psychology. Formulate a preliminary treatment plan within three days of program participation after admission. Replace it within 30 calendar days by a comprehensive, formalized plan using the comprehensive assessment.



This individual treatment plan should reflect the patient's diagnosis and the patient's strengths and weaknesses and identify areas of therapeutic focus. Relate the treatment goals (general statements of consumer outcomes) to identified strengths, weaknesses, and clinical needs with time-limited, measurable objectives. Outline:

- ◆ The hours and frequency the patient will participate in the program.
- ◆ The type of services the patient will receive.
- ◆ The expected duration of the program.


Objectives shall be related to the goal and have specific anticipated outcomes. State the methods that will be used to pursue the objectives. Review and revise as needed the plan but review at least every 30 calendar days.

5. Discharge Criteria

The length of stay in a day treatment program for children shall not exceed 180 treatment days per episode of care. For patients whose length of stay exceeds 180 treatment days, document the rationale for continued stay in the patient's case record and treatment plan every 30 calendar days after the first 180 treatment days.

Discharge criteria for the day treatment program for children shall incorporate at least the following indicators:

- ◆ If the patient has improved:
 - The patient's clinical condition has improved, as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient's developmental level.
 - Reduced interference with and increased responsibility with social, vocational, interpersonal, or education goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.
 - Treatment goals in the individualized treatment plan have been achieved.
 - An aftercare plan has been developed that is appropriate to the patient's needs and agreed to by the patient and family, custodian, or guardian.

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◆ If the patient does not improve:

- The patient's clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.
- Patient, family, or custodian noncompliance with treatment or with program rules exists.

Postdischarge services shall include a plan for discharge that provides appropriate continuity of care.

6. Coordination of Services

Provide programming services in accordance with the individual treatment plan. Appropriate day treatment staff, develop the plan in collaboration with the patient and appropriate caretaker figure (parent, guardian, or principal caretaker). The services shall be under the supervision of the program director, coordinator, or supervisor.

Primary care staff of the CMHC shall coordinate the program for each patient. The day treatment program shall offer a coordinated, consistent array of scheduled therapeutic services and activities. These may include counseling or psychotherapy, theme groups, social skills development, behavior



management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist of active treatment components which are determined by the individual treatment plan based upon a comprehensive evaluation of patient needs, as well as specifically addressing the targeted problems of the population served.

Active treatment has been defined as treatment in which the therapist assumes significant responsibility and often intervenes.

Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment.


Medicaid will not make separate payment for family therapy services. Persons who have reached majority, either by age or emancipation, are exempt from family therapy involvement.

Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

7. Stable Milieu

The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the


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participants, such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient's social and emotional functioning.

To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.

8. Documentation

The program shall maintain a distinct clinical record for each patient admitted. At a minimum, documentation shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient's progress.

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Example 1. John Jones' Clinical Record:

Day treatment services provided June 1, 1993, from 9:00 a.m. to 11:00 a.m. at Brookes CMHC.

Objective:

Will develop and maintain a relapse prevention plan including action steps to take in order to stop his offense cycle.

Treatment Note:

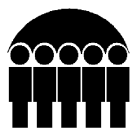
Arrives late looking very disheveled. Begins with making a lot of excuses with rapid speech and flushed cheeks. Give feedback regarding observing his anxiety at "not being perfect" (trigger for cycle) went over his thinking - I'm too busy - what self-talk would put him back into control (positively). Also informed "my family is moving." Another trigger - discussed strategies for dealing with this to prevent relapse. Joe Brown, MSW

Objective:

Increase the use of "I statements" in communications.

Treatment Note:

Reports being more open with Mom when Mom makes hurtful comments. States he uses "I statements." He said his Mom often responds saying "you take things too personally." This was discussed and he acknowledged Mom's response intensifies his hurt and anger... but he doesn't continue to express himself. He states he will talk to Mom and continue using "I" statements. Suzy Smith, RN



Example 2. Dawn Williams' Clinical Record:

Day treatment services provided June 2, 1993, from 1:00 p.m. to 4:00 p.m. at Brookes.

Objective:

Identifies and processes feelings about parental divorce.

Treatment Note:

Processed sense of loss. Identified multiple facets to her loss - parental absence, changes in family patterns. Discussed desire to get things "right" in her behavior and parents will reunite.

Interventions: Normalized grief. Empathized with loss. Did reality testing around issue of reconciling parents.

Joe Brown, MSW


Objective:

Will use weekly play therapy to express feelings.

Treatment Note:

Used play time to work on family unity, nurturing and structure themes. Played out resolution to conflict. Also played out her improved self-esteem.

Suzy Smith, RN

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III. BASIS OF PAYMENT FOR SERVICES

Basis of payment for CMHC services is the center's usual, customary, and reasonable charge for the staff member rendering the service, not to exceed a maximum established by the Department. You may obtain a copy of the fee schedule by contacting the fiscal agent.

Payment for group therapy is based on the actual number of persons who comprise the group, but not less than six. For example, if eight persons are considered to comprise the group, payment is based on eight persons. However, if the group is composed of four persons, payment is nevertheless based on six persons.

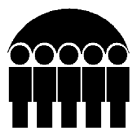
Day treatment services are considered a total package of services. Do not bill individual therapy or group therapy services separately to Medicaid when these therapy services are being provided during hours in which the patient is being served by your day treatment program.

IV. PROCEDURE CODES AND NOMENCLATURE

To expedite the processing of claims for psychiatric services, a list of psychiatric codes has been developed. CPT-4 codes are used where possible. However as the CPT-4 codes do not define the discipline of the person rendering the service, it is still necessary to use codes that have been developed for Medicaid. These codes have a letter in the first position.

The following list defines how the codes should be used (by their descriptions) and whether time units should be used when billing for the codes. Use of these codes does not eliminate the following information, which is still needed on the claim form:

- ◆ In the description area, enter the discipline of the person rendering the service (psychiatrist, psychologist, social worker, psychiatric nurse).
- ◆ Interview or examination, psychological testing, and individual psychotherapy codes are reimbursed according to time increments of 15 minutes. In the description area of the claim form, indicate the total time you are billing for (30 minutes, 1 hour, etc.). In the units column, show one unit for each 15-minute interval.



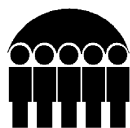
- ◆ Group psychotherapy codes are reimbursed according to time increments of one hour or one and one-half hours. In the description area of the claim form, show the total time you are billing for. In the units column, show one unit for each hour or each hour and a half, depending on the code that is used.

Group therapy codes also require that you indicate on the claim form the number of people in the group. Show this in the procedure code modifier column next to the appropriate procedure code (e.g., W0757-08). Do not show the number of people in the units column.

- ◆ Codes that do not indicate “time” in the description of the code are not reimbursed according to time. Therefore, in the units column, always show one unit for one service.
- ◆ Use modifier “Z1” after each service that is billed as a result of an EPSDT (early and periodic screening, diagnosis, and treatment) physical.

A. Interview or Examination

- 90801 Psychiatric diagnostic interview examination, including history, mental status, or disposition, by psychiatrist, per 15 minutes. (May include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances other informants are seen instead of the patient.)
- W0702 Psychiatric diagnostic interview or examination, including history, mental status, or disposition, by psychologist, social worker, or psychiatric nurse, per 15 minutes. (May include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances other informants are seen instead of the patient.)
- W0727 Brief interview by psychiatrist when initial interview or examination is not performed by psychiatrist, per 15 minutes. Note: Use this code in conjunction with W0702.



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96100 Psychological testing by psychologist, per 15 minutes

W0511 Drug administration and brief office call

Nursing home preadmission, screening, and annual resident review (PASARR):

W0710 Evaluation of client with mental illness

W0711 Evaluation of client with mental retardation

W0712 Evaluation of client with related condition

Note: If the client is both mentally ill and mentally retarded, use two procedure codes and prorate the time.

Diagnostic evaluation required by law before a voluntary admission to one of the state mental health institute:

W0735 By a psychologist, per 15 minutes

W0736 By a social worker, per 15 minutes

W0737 By a psychiatric nurse, per 15 minutes

W0854 Testing of client for mental retardation

W0855 Evaluation of client for mental retardation

B. Consultations

Note: For a consultation to be payable, the service must be provided at the request of another physician. Enter the name of the referring physician on the claim form in the referring physician area.


Office or outpatient consultation for a new or established patient:

99241 Consultation requiring a problem-focused history and examination and straightforward decision making.

99242 Consultation requiring an expanded problem-focused history and examination and straightforward decision making.

99243 Consultation requiring a detailed history and examination and decision making of low complexity.

99244 Consultation requiring a comprehensive history and examination and decision making of moderate complexity.

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99245 Consultation requiring a comprehensive history and examination and decision making of high complexity.

Initial inpatient consultation for a new or established patient:

99251 Consultation requiring a problem-focused history and examination and straightforward decision making.

99252 Consultation requiring an expanded problem-focused history and examination and straightforward decision making.

99253 Consultation requiring a detailed history and examination and decision making of low complexity.

99254 Consultation requiring a comprehensive history and examination and decision making of moderate complexity.

99255 Consultation requiring a comprehensive history and examination and decision making of high complexity.

C. Individual Psychotherapy

90841 Individual medical psychotherapy with continuing medical diagnostic evaluation and drug management, when indicated, including psychoanalysis, insight-oriented, behavior-modifying or supportive psychotherapy, by psychiatrist, per 15 minutes.

90843 Medicaid does not use this code; refer to 90841

90844 Medicaid does not use this code; refer to 90841

W0744 Individual psychotherapy by psychologist, per 15 minutes

W0745 Individual psychotherapy by social worker, per 15 minutes

W0746 Individual psychotherapy by psychiatric nurse, per 15 minutes

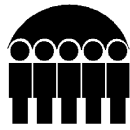
D. Family Therapy

W0566 Family therapy by psychiatric nurse, per 15 minutes

W0567 Family therapy by social worker, per 15 minutes

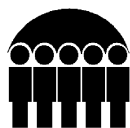
W0568 Family therapy by psychologist, per 15 minutes

W0569 Family therapy by psychiatrist, per 15 minutes



E. Group Psychotherapy

- W0756 Group psychotherapy by psychiatrist, per hour
- W0757 Group psychotherapy by psychologist, per hour
- W0758 Group psychotherapy by social worker, per hour
- W0759 Group psychotherapy by psychiatric nurse, per hour
- W0770 Group psychotherapy by two psychiatrists, per hour
- W0771 Group psychotherapy by psychiatrist and psychologist, per hour
- W0772 Group psychotherapy by two psychologists, per hour
- W0773 Group psychotherapy by social worker and psychiatrist, per hour
- W0774 Group psychotherapy by social worker and psychologist, per hour
- W0775 Group psychotherapy by two social workers, per hour
- W0776 Group psychotherapy by psychiatric nurse and psychiatrist, per hour
- W0777 Group psychotherapy by psychiatric nurse and psychologist, per hour
- W0778 Group psychotherapy by psychiatric nurses and social workers, per hour
- W0779 Group psychotherapy by two psychiatric nurses, per hour
- W0786 Group psychotherapy by psychiatrist, per 1 1/2 hours
- W0787 Group psychotherapy by psychologist, per 1 1/2 hours
- W0788 Group psychotherapy by social worker, per 1 1/2 hours
- W0789 Group psychotherapy by psychiatric nurse, per 1 1/2 hours
- W0790 Group psychotherapy by two psychiatrists, per 1 1/2 hours
- W0791 Group psychotherapy by psychiatrist and psychologist, per 1 1/2 hours
- W0792 Group psychotherapy by two psychologists, per 1 1/2 hours
- W0793 Group psychotherapy by social worker and psychiatrist, per 1 1/2 hours
- W0794 Group psychotherapy by social worker and psychologist, per 1 1/2 hours



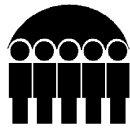
- W0795 Group psychotherapy by two social workers, per 1 1/2 hours
- W0796 Group psychotherapy by psychiatric nurse and psychiatrist, per 1 1/2 hours
- W0797 Group psychotherapy by psychiatric nurse and psychologist, per 1 1/2 hours
- W0798 Group psychotherapy by psychiatric nurse and social worker, per 1 1/2 hours
- W0799 Group psychotherapy by two psychiatric nurses, per 1 1/2 hours

F. Day Treatment

- W0583 Day treatment services for adults, per hour. One session of day treatment must involve between three to five hours of service. Reimbursement for day treatment shall not exceed four units (hours) per session, three or four times per week.
- W0584 Day treatment services for children, per hour. Reimbursement for day treatment shall not exceed 15 units (hours) per week. (Bill this code for a calendar month. Note the number of treatment days in the calendar month billing period in the "procedures, services, or supplies" field of the claim form.)

G. Miscellaneous Therapy

- 90835 Narcosynthesis for psychiatric diagnostic and therapeutic purposes, e.g., sodium amobarbital (Amytal) interview
- 90862 Pharmacologic management, including prescription, use, and review of medication, with not more than minimal medical psychotherapy (for psychiatrist services only)
- 90870 Electroconvulsive therapy (single seizure)
- 90871 Electroconvulsive therapy (multiple seizures)



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H. Medications


J1630 Haloperidol Deconoate, per 5 mg

J1631 Haloperidol Deconoate, per 50 mg

J2680 Fluphenazine Deconoate, up to 25 mg

90782 Therapeutic or diagnostic injections; subcutaneous or intramuscular

Note: When Medicaid recipients bring in their medications for injection, bill only CPT code 90782 for injection administration. When CMHC medicine is used, bill the medication code along with CPT code 90782.


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I. ENHANCED SERVICES REPORTING AND INSTRUCTIONS

The Iowa Legislature has appropriated special funds to the Department of Human Services for certain Medicaid services provided to persons with a primary diagnosis of mental retardation, chronic mental illness, or developmental disability. The special services for which these funds are available are partial hospitalization, day treatment, and case management.

Definitions for the three categories of primary diagnosis are as follows:

- ◆ Mental retardation means significantly subaverage general intellectual functioning, existing concurrently with deficits in adaptive behavior, manifested during the developmental period. “General intellectual functioning” is defined as the results obtained from one or more of the individually administered general intelligence tests designed for this purpose. “Significant subaverage functioning” is defined as approximately an intelligent quotient (IQ) of 70 or below. “Adaptive behavior” is defined as the effectiveness or degree with which people meet standards of personal independence and social responsibility expected for age and cultural group. “Developmental period” is defined as the period of time between conception and the eighteenth birthday.
- ◆ Chronic mental illness means mental or emotional disorder that seriously impairs a person’s functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment. Persons with chronic mental illness typically have undergone psychiatric treatment more intensive than outpatient care more than once or have experienced at least one episode of continuous structured, supportive, residential care other than hospitalization. In addition, they typically meet at least two of the following criteria on a continuing or intermittent basis for at least two years:
 - Are unemployed or employed in a sheltered setting, or have markedly limited skills, and a poor work history.
 - Require financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.

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- Show severe inability to establish or maintain a personal social support system.
- Require help in basic living skills.
- Exhibit inappropriate social behavior which results in demand for intervention by the mental health or judicial system.

In atypical instances, a person may vary from the above criteria and could still be considered a person with chronic mental illness.

- ♦ Developmental disabilities means severe, chronic disabilities which:
 - Are attributable to mental or physical impairment, or a combination of mental and physical impairment.
 - Are manifested before the person attains the age of 22.
 - Are likely to continue indefinitely.
 - Result in substantial functional limitation in three or more of the following areas of life activities:
 - Self care
 - Receptive and expressive language
 - Learning
 - Mobility
 - Self-direction
 - Capacity for independent living
 - Economic self-sufficiency
 - Reflect the person's need for a combination and sequence of services which are of lifelong or extended duration.

To ensure proper allocation of funds, the Department must receive a report on each Medicaid recipient receiving partial hospitalization, day treatment, or case management services who falls in one of the above three diagnostic categories. This report contains information concerning the diagnostic category into which the recipient falls, and the recipient's county of legal settlement.

A. Report for Enhanced Services, Form 470-2464

(See the following page.)

Iowa Department of Human Services

REPORT FOR ENHANCED SERVICES**Section A.** Completed by provider.

| | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------|---------------------------------------|-------------------|----------|
| Recipient Name (Last, First, M.I.) | | Birth Date | | State I.D. Number | |
| Street | | City | | State | Zip Code |
| County of Legal Settlement (name and number) | | | Date Legal Responsibility was Assumed | | |
| Primary Diagnosis <input type="checkbox"/> Mental Retardation (M) <input type="checkbox"/> Chronic Mental Illness (I) <input type="checkbox"/> Developmental Disability (S) | | | | | |
| Provider Name | | Provider Number | | Telephone Number | |
| Street | | City | | State | Zip Code |
| Service <input type="checkbox"/> Case Management <input type="checkbox"/> Day Treatment <input type="checkbox"/> Partial Hospitalization | | | | | |
| Director or Designee Signature | | | | | |


Section B. Completed by Department of Human Services.

| | | |
|---------------|--------------|-----------|
| Date Received | Date Entered | Signature |
|---------------|--------------|-----------|

470-2464 (4/90)

Copy 1: Local Department of Human Services Office

Copy 2: Provider

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B. Instructions for Completing the Form

Form 470-2464 is completed when a Medicaid recipient in one of the three diagnostic categories is accepted for partial hospitalization, day treatment, or case management services.

Section A of this form is completed by the provider of services.


Providers are required to enter the name and number of the recipient's county of legal settlement. To assist providers in making that determination, information on Iowa's legal settlement laws is provided in the next section of this chapter. If payment for services to a recipient is the responsibility of the state and not the county, the provider should enter "00" on the form under county of legal settlement.

Enter the date on which the county assumed financial responsibility for the recipient for whom the form is being submitted. This may be the date services were initiated by the provider. Enter a check in the box preceding the primary diagnosis and in the box preceding the service. Providers should retain one copy of the completed form for their records.

Forward a copy of the completed form to the following address:

Department of Human Services
Quality Assurance Unit
Hoover Building
Des Moines, Iowa 50319-0114

Section B of the form is completed by the Department of Human Services.

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C. Information to Determine Legal Settlement

1. Definitions

Legal settlement. “Legal settlement” is a status defined in Iowa law as acquired by a person when a specific county is identified as having a financial responsibility for that person.


Residence. A person’s residence is defined as where the person is currently living. The courts have interpreted residence very broadly. Residence can be established without regard to length of time. Example:

Ms. A arrives in Des Moines today from another state, rents an apartment, and moves in. As of today, she is a resident of the city of Des Moines, the county of Polk, and the state of Iowa. Residence does not require living in Des Moines for any specific reason.

The question of intent is frequently raised. The only intent required is, “This is where I intend to live for now.” You can be a resident of Des Moines today and Omaha tomorrow. Some interpretations state that you may have more than one residence simultaneously.

Continuously. “Continuously” means a person has maintained a residence in the same county without interruption. It does not necessarily mean never being absent from the county. The Department currently defines a period of hospitalization in a state institution as an interruption in the continuous period. When the continuous period is interrupted, the period starts again from the beginning when the person returns to reside in the county. Example:

Mr. J has legal settlement in County X, but six months ago moved and established residence in County Y. Mr. J is hospitalized at an MHI and discharged five months later. Under this definition, Mr. J does not acquire legal settlement in County Y until one continuous year after his discharge from the MHI, provided there are no further hospitalizations or services received.

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Durational residency. “Durational residency” is having residence in a particular place for a specific length of time. Legal settlement is a durational residency because it requires continuous residency within the county for a one-year period of time.

State case. The term “state case” is a phrase used to identify the condition where a person has no county of legal settlement. This condition does not automatically create a state financial responsibility.

Institution. “Institution” has been defined by the Iowa Supreme Court as “an established society or corporation, which may be private in character and designed for profit, or it may be public and charitable in purpose.” As a rule of thumb, this means any entity licensed under Iowa Code Chapter 135C as a health care facility, or approved by the Department of Human Services, i.e., community supervised living arrangement.


2. How Legal Settlement is Acquired

a. Adults

The basic Code provision for determining legal settlement is Iowa Code Section 252.16(1), which states: “A person continuously residing in a county in this state for a period of one year acquires a settlement in that county except as provided in subsection 7 or 8.”

This provision applies individually to adults. In a family situation, each adult member acquires legal settlement independently of the other. The wife no longer takes her husband’s legal settlement. It is possible for two spouses to have two separate legal settlements.

The only other way for an adult to acquire legal settlement is at the time a minor achieves majority (legally becomes an adult). Upon achieving majority, persons acquire, as their own legal settlement, the legal settlement of their parents or legal guardian.

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b. Minor Children

Two other sections of the Code specify how a minor child acquires legal settlement. Iowa Code Section 252.16(4) states: “Minor children who reside with both parents take the settlement of the parents. If the minor child resides on a permanent basis with only one parent or a guardian, the minor child takes the settlement of the parent or guardian with whom the child resides.

“An emancipated minor acquires a legal settlement in the minor’s own right. An emancipated minor is one who is absent from the minor’s parents with the consent of the parents, is self-supporting, and has assumed a new relationship inconsistent with being a part of the family of the parents.

“A minor placed in the care of a public agency or facility as custodian or guardian takes the legal settlement that the parents had upon severance of the parental relationship and retains that legal settlement until a natural person is appointed custodian or guardian. At which time the minor takes the legal settlement of the natural person or until the minor person attains the age of eighteen and acquires another legal settlement in the person’s own right.”

Basically, a minor child takes the legal settlement of the parent or a court-appointed legal guardian. When a child’s parents are not residing together, the child takes the legal settlement of the custodial parent.

When a minor child lives outside the parental home, and no legal guardian has been appointed, the minor child’s legal settlement is still tied to the parent. A minor child in the custody of an institution, agency, or foster home still takes the legal settlement of the parent until the child attains majority. Once majority is attained, the child retains the legal settlement acquired at that time, until the child leaves the custody of an institution. Legal settlement is then lost or changed according to the provisions for adults.



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When parental rights are terminated and a natural person is appointed guardian, the minor child takes the legal settlement of the guardian. When the guardian is a public agency or facility, the minor child takes the legal settlement of the parent at the time of termination. The minor child retains that legal settlement until a natural person is appointed guardian or attains majority at which time the laws governing the losing or changing legal settlement are followed. Any subsequent change in the natural parent's legal settlement has no impact on the minor.


c. Blind Person

A blind person acquires legal settlement after only six months of continuous residence in a county.

Iowa Code Section 252.16(6) states: "Subsection 1, 2, 3, and 7 do not apply to a blind person who is receiving assistance under the laws of this state. A blind person receiving assistance who has resided in one county of this state for a period of six months acquires legal settlement for support as provided in this Chapter."

d. Military Personnel

Military personnel receive special attention on establishing or losing legal settlement. Iowa Code Section 252.16(5) states: "A person with settlement in this state who becomes a member on active duty of an armed services of the United States retains the settlement during the period of active duty. A person without settlement in this state who is a member on active duty of an armed service of the United States within the borders of this state does not acquire legal settlement during the period of active duty."

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A person with legal settlement who enlists voluntarily or is inducted involuntarily into active military status retains legal settlement during the person's period of active military duty. This provision does not apply to a spouse of the person in the military. The spouse loses legal settlement if the spouse moves out of the state for one year. A person who does not have legal settlement and who is serving on active duty in the military within the state cannot acquire legal settlement. This does not prohibit a spouse from acquiring legal settlement after living in a county for one continuous year.

e. Inmate of or Supported by an Institution

A person who is living in or is being supported by an institution cannot acquire or change legal settlement.

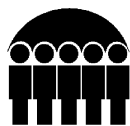
“Living in” includes persons physically present or actually residing within an institution, but also can include persons who are not. When an institution has a court-directed legal obligation for the person, i.e., a person on limited leave from a mental health institute, the person may still be considered as an inmate of the institution.

“Supported by” is limited to the provisions of the necessities of life, including food, clothing, shelter, and appropriate care. The provision of counseling or other social services is not included.

3. Host County

The 1987 Legislature added a new paragraph (8) to Iowa Code Section 252.16, effective July 1, 1987, which states: “A person receiving treatment or support services from any community-based provider of treatment or services for mental retardation, developmental disabilities, mental health, or substance abuse does not acquire legal settlement in the host county unless the person continuously resides in the host county for one year from the date of the last treatment or support services received by the person.”

The Legislature did not define “treatment or support services” or “community-based provider.”



4. How Legal Settlement is Changed or Lost

Iowa Code Section 252.16(2) states: “A person having acquired a settlement in a county of this state shall not acquire a settlement in any other county until the person has continuously resided in the other county for a period of one year except as provided in subsection 7.”


To change legal settlement from one county to another, an adult has to follow the same process for originally acquiring legal settlement. The person has to continuously reside in the new county for one year. A person does not lose legal settlement in the original county until legal settlement is acquired in a new county. A person with legal settlement in a county may live outside that county for years and still retain legal settlement in that county by never leaving the state and never living in another county for one continuous year.

Iowa Code Section 252.17 states: “A legal settlement once acquired shall so remain until such person has removed from this state for more than one year or has acquired a legal settlement in some other county or state.”

The only way an adult with legal settlement can ever totally lose legal settlement is to move out of the state. Legal settlement is then lost after the person has been out of the state for one year, or has acquired legal settlement in another state in less than one year. A person leaving the state for active military duty is an exception, as noted earlier.

An adult living in a county where a mental health institute or a state hospital-school is located and who is receiving treatment from the institution cannot acquire legal settlement in that county until the person has lived in the county for one year without any treatment.

Iowa Code Section 252.16(7) states: “A person hospitalized in or receiving treatment at a state mental health institute or state hospital-school does not acquire legal settlement in the county in which the institute or hospital-school is located unless the person is discharged from the institute or hospital-school, continuously resides in the county for a period of one year subsequent to the discharge, and during that year is not hospitalized in and does not receive treatment at the institute or hospital-school.”

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Iowa Code Section 252.22 contains an exception to a person changing legal settlement when the current county of legal settlement agrees to maintain the person in another county: “When relief is granted to a poor person having a settlement in another county, the auditor shall at once by mail notify the auditor of the county of settlement of that fact, and within fifteen days after receipt of the notice, the auditor shall inform the auditor of the county granting relief if the claim of settlement is disputed. If it is not, the poor person, at the request of the auditor or board of supervisors of the county of settlement, may be maintained where the person then is at the expense of the county of legal settlement, and without affecting legal settlement as provided in Section 252.16.”

This section permits the two counties to enter into an agreement in which the county of legal settlement agrees to support the person in another county. As long as that agreement is in effect and the person is being supported, the person’s legal settlement does not change.

II. INSTRUCTIONS AND CLAIM FORM

A. Instructions for Completing the Claim Form

The table below contains information that will aid in the completion of the HCFA-1500 claim form. The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual recipient’s situation.

A star (*) in the instructions area of the table indicates a new item or change in policy for Iowa Medicaid providers.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.



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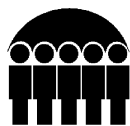
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| FIELD NUMBER | FIELD NAME/ DESCRIPTION | INSTRUCTIONS |
|--------------|---------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. | CHECK ONE | OPTIONAL – Check the applicable program block. |
| 1a. | INSURED'S ID NUMBER | REQUIRED – Enter the recipient's Medicaid ID number found on the <i>Medical Assistance Eligibility Card</i> . It should consist of seven digits followed by a letter, i.e., 1234567A. |
| 2. | PATIENT'S NAME | REQUIRED – Enter the last name, first name and middle initial of the recipient. Use the <i>Medical Assistance Eligibility Card</i> for verification. |
| 3. | PATIENT'S BIRTHDATE | OPTIONAL – Enter the patient's birth month, day, year and sex. Completing this field may expedite processing of your claim. |
| 4. | INSURED'S NAME | <p>CONDITIONAL* – If the recipient is covered under someone else's insurance, enter the name of the person under which the insurance exists. This could be insurance covering the recipient as a result of a work or auto related accident.</p> <p>Note: This section of the form is separated by a border, so that information on this other insurance follows directly below, even though the numbering does not.</p> |
| 5. | PATIENT'S ADDRESS | OPTIONAL – Enter the address and phone number of the patient, if available. |
| 6. | PATIENT RELATIONSHIP TO INSURED | CONDITIONAL* – If the recipient is covered under another person's insurance, mark the appropriate box to indicate relation. |
| 7. | INSURED'S ADDRESS | CONDITIONAL* – Enter the address and phone number of the insured person indicated in field number 4. |



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| 8. | PATIENT STATUS | OPTIONAL – Check boxes corresponding to the patient’s current marital and occupational status. |
| 9a-d. | OTHER INSURED’S NAME | CONDITIONAL* – If the recipient carries other insurance, enter the name under which that insurance exists, as well as the policy or group number, the employer or school name under which coverage is offered and the name of the plan or program. |
| 10. | IS PATIENT’S CONDITION RELATED TO | CONDITIONAL* – Check the appropriate box to indicate whether or not treatment billed on this claim is for a condition that is somehow work or accident related. If the patient’s condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the “YES” and “NO” boxes. |
| 10d. | RESERVED FOR LOCAL USE | OPTIONAL – No entry required. |
| 11a-c. | INSURED’S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION | CONDITIONAL* – This field continues with information related to field 4. If the recipient is covered under someone else’s insurance, enter the policy number and other requested information as known. |
| 11d. | IS THERE ANOTHER HEALTH BENEFIT PLAN? | CONDITIONAL – If payment has been received from another insurance, or the medical resource codes on the eligibility card indicate other insurance exists, check “YES” and enter payment amount in field 29. If you have received a denial of payment from another insurance, check <u>both</u> “YES” and “NO” to indicate that there is other insurance, but that the benefits were denied. Note: Auditing will be performed on a random basis to ensure correct billing. |



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| 12. | PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE | OPTIONAL – No entry required. |
| 13. | INSURED OR AUTHORIZED PERSON'S SIGNATURE | OPTIONAL – No entry required. |
| 14. | DATE OF CURRENT ILL- NESS, INJURY, PREGNANCY | CONDITIONAL* – Chiropractors must enter the date of the onset of treatment as month, day and year. All others – no entry required. |
| 15. | IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS... | CONDITIONAL – Chiropractors must enter the current x-ray date as month, day and year. All others – no entry required. |
| 16. | DATES PATIENT UNABLE TO WORK... | OPTIONAL – No entry required. |
| 17. | NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | CONDITIONAL – Required if the referring physician does not have a Medicaid number. |
| 17a. | ID NUMBER OF REFERRING PHYSICIAN | <p>CONDITIONAL* –</p> <p>If the patient is a MediPASS recipient and the MediPASS physician authorized service, enter the seven-digit MediPASS authorization number.</p> <p>If this claim is for consultation, independent lab or DME, enter the Iowa Medicaid number of the referring or prescribing physician.</p> <p>If the patient is on lock-in and the lock-in physician authorized service, enter the seven-digit authorization number.</p> |



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| 18. | HOSPITALI- ZATION DATES RELATED TO... | OPTIONAL – No entry required. |
| 19. | RESERVED FOR LOCAL USE | REQUIRED – If the patient is pregnant, write “Y – Pregnant.” |
| 20. | OUTSIDE LAB | OPTIONAL – No entry required. |
| 21. | DIAGNOSIS OR NATURE OF ILLNESS | REQUIRED – Indicate the applicable ICD-9-CM diagnosis codes in order of importance (1-primary; 2-secondary; 3-tertiary; and 4-quaternary) to a maximum of four diagnoses. |
| 22. | MEDICAID RESUBMISSION CODE... | OPTIONAL – No entry required. |
| 23. | PRIOR AUTHORIZATION NUMBER | CONDITIONAL* – Enter the prior authorization number issued by ACS. |
| 24. A | DATE(S) OF SERVICE | REQUIRED – Enter month, day and year under both the From and To categories for each procedure, service or supply. If the From-To dates span more than one calendar month, represent each month on a separate line. Because eligibility is approved on a month-by-month basis, spanning or overlapping billing months could cause the entire claim to be denied. |



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| 24. B | PLACE OF SERVICE | <p>REQUIRED – Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters.</p> <ul style="list-style-type: none">11 Office12 Home21 Inpatient Hospital22 Outpatient Hospital23 Emergency Room – Hospital24 Ambulatory Surgical Center25 Birthing Center26 Military Treatment Facility31 Skilled Nursing32 Nursing Facility33 Custodial Care Facility34 Hospice41 Ambulance – land42 Ambulance – air or water51 Inpatient Psychiatric Facility52 Psychiatric Facility – partial hospitalization53 Community Mental Health Center54 Intermediate Care Facility/Mentally Retarded55 Residential Substance Abuse Treatment Facility56 Psychiatric Residential Treatment Center61 Comprehensive Inpatient Rehabilitation Facility62 Comprehensive Outpatient Rehabilitation Facility65 End-stage Renal Disease Treatment71 State or Local Public Health Clinic72 Rural Health Clinic81 Independent Laboratory99 Other Unlisted Facility |
|-------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|



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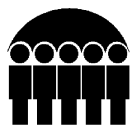
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| 24. C | TYPE OF SERVICE | OPTIONAL – No entry required. |
| 24. D | PROCEDURES, SERVICES OR SUPPLIES | REQUIRED – Enter the appropriate five-digit procedure code and any necessary modifier for each of the dates of service. DO NOT list services for which no fees were charged. |
| 24. E | DIAGNOSIS CODE | REQUIRED – Indicate the corresponding diagnosis code from field 21 by entering the number of its position, i.e., 3. DO NOT write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim. |
| 24. F | \$ CHARGES | REQUIRED – Enter the usual and customary charge for each line item. |
| 24. G | DAYS OR UNITS | REQUIRED – Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter “1.” When billing general anesthesia, the units of service must reflect the <u>total minutes</u> of general anesthesia. |
| 24. H | EPSDT/FAMILY PLANNING | OPTIONAL* – Enter an “F” if the services on this claim line are for family planning. Enter an “E” if the services on this claim line are the result of an EPSDT Care for Kids screening. |
| 24. I | EMG | OPTIONAL – No entry required. |
| 24. J | COB | OPTIONAL – No entry required. |
| 24. K | RESERVED FOR LOCAL USE | CONDITIONAL* – Enter the treating provider’s individual seven-digit Iowa Medicaid provider number when the provider number given in field 33 is that of a group and/or is not that of the treating provider. |
| 25. | FEDERAL TAX ID NUMBER | OPTIONAL – No entry required. |
| 26. | PATIENT’S ACCOUNT NUMBER | OPTIONAL – Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters. |



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| 27. | ACCEPT ASSIGNMENT? | OPTIONAL – No entry required. |
| 28. | TOTAL CLAIM CHARGE | REQUIRED – Enter the total of the line item charges. If more than one claim form is used to bill services performed, each claim form must be separately totaled. Do not carry over any charges to another claim form. |
| 29. | AMOUNT PAID | CONDITIONAL* – Enter only the amount paid by other insurance. Recipient co-payments, Medicare payments or previous Medicaid payments are not listed on this claim. |
| 30. | BALANCE DUE | REQUIRED* – Enter the amount of total charges less the amount entered in field 29. |
| 31. | SIGNATURE OF PHYSICIAN OR SUPPLIER | REQUIRED – The signature of either the physician or authorized representative and the original filing date must be entered. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used. |
| 32. | NAME AND ADDRESS OF FACILITY... | CONDITIONAL – If other than a home or office, enter the name and address of the facility where the service(s) were rendered. |
| 33. | PHYSICIAN'S, SUPPLIER'S BILLING NAME... | REQUIRED* – Enter the complete name and address of the billing physician or service supplier. |
| | GRP # | REQUIRED – Enter the seven-digit Iowa Medicaid number of the billing provider. If this number identifies a group or an individual provider other than the provider of service, the treating provider's Iowa Medicaid number must be entered in field 24K for each line. |
| BACK OF FORM | NOTE | REQUIRED – The back of the claim form must be intact on every claim form submitted. |

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B. Facsimile of Claim Form, HCFA-1500 (front and back)

(See the following pages.)

PICA

HEALTH INSURANCE CLAIM FORM

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| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> | | 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) | |
| (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> (SSN) <input type="checkbox"/> (ID) <input type="checkbox"/> | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | | 3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | |
| 5. PATIENT'S ADDRESS (No., Street) | | 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> | |
| CITY | | 7. INSURED'S ADDRESS (No., Street) | |
| STATE | | CITY | |
| ZIP CODE | | STATE | |
| TELEPHONE (Include Area Code) | | ZIP CODE | |
| () | | TELEPHONE (INCLUDE AREA CODE) | |
| () | | () | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | 10. IS PATIENT'S CONDITION RELATED TO: | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | | b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ | |
| c. EMPLOYER'S NAME OR SCHOOL NAME | | c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | 10d. RESERVED FOR LOCAL USE | |
| 11. INSURED'S POLICY GROUP OR FECA NUMBER | | | |
| a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | | | |
| b. EMPLOYER'S NAME OR SCHOOL NAME | | | |
| c. INSURANCE PLAN NAME OR PROGRAM NAME | | | |
| d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d. | | | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____ | | | |
| 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ | | | |
| 14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | 17a. I.D. NUMBER OF REFERRING PHYSICIAN | |
| 19. RESERVED FOR LOCAL USE | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | | 20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 1. _____ | | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. | |
| 2. _____ | | 23. PRIOR AUTHORIZATION NUMBER | |
| 3. _____ | | | |
| 4. _____ | | | |
| 24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY | | B Place of Service | |
| C Type of Service | | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | |
| E DIAGNOSIS CODE | | F \$ CHARGES | |
| G DAYS OR UNITS | | H EPSDT Family Plan | |
| I EMG | | J COB | |
| K RESERVED FOR LOCAL USE | | | |
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> | | 26. PATIENT'S ACCOUNT NO. | |
| 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28. TOTAL CHARGE \$ | |
| 29. AMOUNT PAID \$ | | 30. BALANCE DUE \$ | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | | 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) | |
| 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # | | | |
| SIGNED _____ DATE _____ | | PIN# _____ GRP# _____ | |

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)


I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

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III. REMITTANCE ADVICE AND FIELD DESCRIPTIONS

A. Remittance Advice Explanation


To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims. PAID indicates all processed claims, credits and adjustments for which there is full or partial reimbursement. DENIED represents all processed claims for which no reimbursement is made. SUSPENDED reflects claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the *Medicaid Provider Application* at the time of enrollment. You chose one of the following:

- ◆ Print suspended claims only once.
- ◆ Print all suspended claims until paid or denied.
- ◆ Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a “1” in the twelfth position and reimbursement appears as a negative amount. An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a “2” in the twelfth position of the transaction control number.

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If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit - the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

When contacting the fiscal agent with questions regarding the *Remittance Advice*, refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

B. Facsimile of Remittance Advice and Detailed Field Descriptions

(See the following page.)

MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 06/12/97

REMITTANCE ADVICE

1. TO: [REDACTED] 2. R.A. NO.: 0000006 3. DATE PAID: 05/19/97 PROVIDER NUMBER: [REDACTED] 4. PAGE: 1 5.

**** PATIENT NAME **** REGIP ID / TRANS-CONTROL-NUMBER / BILLED OTHER PAID BY COPAY MED RCD NUM /
LAST FIRST MI LINE SVC-DATE PROC/MODS UNITS AMT. SOURCES MCAID AMT. PERF. PROV. S EOB EOB

* 6. CLAIM TYPE: HCFA 1500

* 7. CLAIM STATUS: PAID

ORIGINAL CLAIMS:

| 8. | 9. | 10. | 11. | 12. | 13. | 14. | 15. | 16. |
|------------|------------|------------------------|-------|-----------|----------|-----------|------------|--------------------------|
| [REDACTED] | [REDACTED] | 4-96331-00-053-0038-00 | 38.00 | 0.00 | 16.06 | 0.00 | 860600608B | 900 000 |
| 17. 01 | 18. 10/3 | 19. 99212 | 20. 1 | 21. 38.00 | 22. 0.00 | 23. 16.06 | 24. 0.00 | 25. [REDACTED] 000 000 |
| [REDACTED] | [REDACTED] | 4-96348-00-018-0060-00 | 50.00 | 0.00 | 35.26 | 0.00 | 860600608B | 000 000 |
| | 01 | 11/15/96 J1055 | 1 | 41.00 | 0.00 | 33.18 | 0.00 | [REDACTED] 26. F 000 000 |
| | 02 | 11/15/96 9C782 | 1 | 9.00 | 0.00 | 2.08 | 0.00 | [REDACTED] F 000 000 |


27.

REMITTANCE T O T A L S

| | | | | |
|-----------------------------|------------------|---|-------|-------|
| PAID ORIGINAL CLAIMS: | NUMBER OF CLAIMS | 2 | 88.00 | 51.32 |
| PAID ADJUSTMENT CLAIMS: | NUMBER OF CLAIMS | 0 | 0.00 | 0.00 |
| DENIED ORIGINAL CLAIMS: | NUMBER OF CLAIMS | 0 | 0.00 | 0.00 |
| DENIED ADJUSTMENT CLAIMS: | NUMBER OF CLAIMS | 0 | 0.00 | 0.00 |
| PENDED CLAIMS (IN PROCESS): | NUMBER OF CLAIMS | 0 | 0.00 | 0.00 |
| AMOUNT OF CHECK: | | | | 51.32 |

----- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:

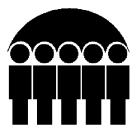
28. 900 THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM.

| | | |
|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------|
|  Iowa Department of Human Services | CHAPTER SUBJECT: BILLING AND PAYMENT COMMUNITY MENTAL HEALTH CENTER | CHAPTER PAGE F - 27 |
| | | DATE December 1, 1998 |

C. Remittance Statement Field Descriptions

1. Pay-to provider name as specified on the *Medicaid Provider Enrollment Application*.
2. *Remittance Advice* number.
3. Date claim paid.
4. Medicaid (Title XIX) pay-to provider number.
5. Recipient last and first name.
6. Recipient Medicaid ID number.
7. Transaction control number assigned by fiscal agent to each claim. Please use this number when making inquiries about claims.
8. Total charges submitted by provider.
9. Total amount applied to this claim from other resources, i.e., other insurance or spenddown.
10. Total amount paid by Medicaid for this claim.
11. Total amount of recipient copayment deducted from this claim.
12. Medical record number as assigned by provider/Medicaid ID number of provider performing services.
13. Allowed charge source code.

| | | | |
|----------|------------------------------|----------|----------------------------------|
| B | Billed charge | F | Fee schedule |
| K | Denied | N | Provider charge rate |
| P | Group therapy | Q | EPSDT total screen over 17 years |
| R | EPSDT total under 18 years | S | EPSDT partial over 17 years |
| T | EPSDT partial under 18 years | U | Gynecology fee |
| V | Obstetrics fee | W | Child fee |



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CHAPTER SUBJECT:

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COMMUNITY MENTAL HEALTH CENTER


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14. Explanation of benefits code indicates the reason for claim denial. Refer to explanation at end of the remittance for each EOB code in the *Remittance Advice*.
15. Line item number.
16. The first date of service for the procedure billed.
17. The procedure code for the service billed.
18. The number of units of service rendered.
19. Remittance totals (found at the end of the *Remittance Advice*).
 - ◆ Number of paid original claims, amount billed, and amount allowed and paid.
 - ◆ Number of paid adjusted claims, amount billed, and amount allowed and paid.
 - ◆ Number of denied original claims, amount billed, and amount allowed and paid.
 - ◆ Number of denied adjusted claims, amount billed, and amount allowed and paid.
 - ◆ Number of pended claims (in process), amount billed, and amount allowed.
 - ◆ Amount of check.
20. Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------|------------------|
|  Iowa Department of Human Services | CHAPTER SUBJECT: BILLING AND PAYMENT COMMUNITY MENTAL HEALTH CENTER | CHAPTER | PAGE |
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IV. PROBLEMS WITH SUBMITTED CLAIMS

To inquire as to why a claim was denied or why a claim payment was not what you expected, please complete form 470-3744, *Provider Inquiry*. Attach copies of the claim, the *Remittance Advice*, and any supporting documentation you want to have considered, such as additional medical records. Send these to:

ACS, Attn: Provider Inquiry
PO Box 14422
Des Moines, Iowa 50306-3422

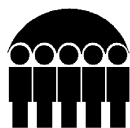
To make an adjustment to a claim following receipt of the *Remittance Advice*, use form 470-0040, *Credit/Adjustment Request*. Use the *Credit/Adjustment Request* to notify the fiscal agent to take an action against a paid claim, such as when:

- ◆ A paid claim amount needs to be changed, or
- ◆ Money needs to be credited back, or
- ◆ An entire *Remittance Advice* should be canceled.

Send this form to:

ACS, Attn: Credits and Adjustments
PO Box 14422
Des Moines, Iowa 50306-3422

Do **not** use this form when a claim has been denied. Denied claims must be resubmitted.



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A. Facsimile of Provider Inquiry, 470-3744

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

B. Facsimile of Credit/Adjustment Request, 470-0040

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

Iowa Medicaid Program
PROVIDER INQUIRY

Attach supporting documentation. Check applicable boxes: ☐ Claim copy ☐ Remittance copy
☐ Other pertinent information for possible claim reprocessing.

| | | | | | | | | | | | | | | | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--|--|--|--|-------------------------------------------------------------|--|--|--|--|--|---------------------|--|--|--|--|--|-------------------------------------------------------------------------------------------------------|--|--|--|--|--|
| 1. 17-DIGIT TCN | | | | | | | | | | | | | | | | | | | | | | | |
| I N Q U I R Y A | 2. NATURE OF INQUIRY | | | | | | | | | | | | | | | | | | | | | | |
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| FISCAL RESPONSE | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. 17-DIGIT TCN | | | | | | | | | | | | | | | | | | | | | | | |
| I N Q U I R Y B | 2. NATURE OF INQUIRY | | | | | | | | | | | | | | | | | | | | | | |
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| FISCAL AGENT RESPONSE | | | | | | | | | | | | | | | | | | | | | | | |
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| | | | | | | | | | | | | | | | | | | | | | | | |
| Provider Signature/Date: | | | | | | MAIL TO: ACS P. O. BOX 14422 DES MOINES IA 50306-3422 | | | | | | ACS Signature/Date: | | | | | | | | | | | |
| <div>Provider Please Complete: 7-digit Medicaid Provider ID# _____ Telephone _____</div> <div>Name _____ Street _____ City, St _____ Zip _____</div> | | | | | | | | | | | | | | | | | | <div>(FOR ACS USE ONLY)</div> <div>PR Inquiry Log # _____</div> <div>Received Date Stamp: _____</div> | | | | | |

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Iowa Medicaid Program

CREDIT/ADJUSTMENT REQUEST

Do **not** use this form if your claim was denied. Resubmit denied claims.

| | | | | | | | | | | | | | | | |
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| SECTION A: Check the most appropriate action and complete steps for that request. | | | | | | | | | | | | | | | |
| <input type="checkbox"/> CLAIM ADJUSTMENT <ul style="list-style-type: none"> ◆ Attach a complete copy of claim. (If electronic, use next step.) ◆ Attach a copy of the Remittance Advice with corrections in red ink. ◆ Complete Sections B and C. | | | | | <input type="checkbox"/> CLAIM CREDIT <ul style="list-style-type: none"> ◆ Attach a copy of the Remittance Advice. ◆ Complete Sections B and C. | | | | | <input type="checkbox"/> CANCELLATION OF ENTIRE REMITTANCE ADVICE <ul style="list-style-type: none"> ◆ Use only if all claims on Remittance Advice are incorrect. This option is rarely used. ◆ Attach the check and Remittance Advice. ◆ Skip Section B. Complete Section C. | | | | | |
| SECTION B: | | | | | | | | | | | | | | | |
| 1. 17-digit TCN | | | | | | | | | | | | | | | |
| 2. Pay-to Provider #: | | | | | | | | 4. 8-character Iowa Medicaid Recipient ID: (e.g., 1234567A) | | | | | | | |
| 3. Provider Name and Address: | | | | | | | | | | | | | | | |
| 5. Reason for Adjustment or Credit Request: | | | | | | | | | | | | | | | |
| SECTION C: | | Provider/Representative Signature: | | | | | | | | | | | | | |
| | | Date: | | | | | | | | | | | | | |
| FISCAL AGENT USE ONLY: REMARKS/STATUS | | | | | | | | | | | | | | | |
| Return All Requests To: <div style="float: right; text-align: right;"> ACS PO Box 14422 Des Moines, IA 50306-3422 </div> | | | | | | | | | | | | | | | |

March 5, 1996

For Human Services Use Only

General Letter No. 8-A-AP(II)-582

Subject: Employees' Manual, Title VIII, Chapter A, Appendix, Part Two

COMMUNITY MENTAL HEALTH CENTER MANUAL TRANSMITTAL NO. 96-1

Subject: ***Community Mental Health Center Manual***, Contents (page 5), revised; Chapter E, *Coverage and Limitations*, pages 7, 8, and 13 through 18, revised.

The prior authorization system for day treatment services through the Iowa Foundation for Medical Care (IFMC) is discontinued. The vast majority of these services are currently authorized under managed care arrangements.

Date Effective

March 1, 1996

Material Superseded

Remove from ***Community Mental Health Center Manual***, Chapter E, pages 7, 8, and 13 through 18, dated June 1, 1993, and destroy them.

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Unisys Corporation, fiscal agent for the Iowa Department of Human Services.

IOWA DEPARTMENT OF HUMAN SERVICES
Charles M. Palmer, Director

Donald W. Herman, Administrator
DIVISION OF MEDICAL SERVICES

October 21, 1996

For Human Services Use Only

General Letter No. 8-AP-3

Subject: Employees' Manual, Title 8, Appendix

COMMUNITY MENTAL HEALTH CENTER MANUAL TRANSMITTAL NO. 96-2

Subject: *Community Mental Health Center Manual*, Chapter E, *Coverage and Limitations*, pages 25 and 26, revised.

This revision:

- ◆ Adds the CPT code for psychological testing. The previous code of W0929 will be discontinued.
- ◆ Adds local codes for services for mental retardation and drug administration.

Date Effective

October 1, 1996

Material Superseded

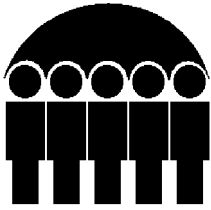
Remove from *Community Mental Health Center Manual*, Chapter E, pages 25 and 26, dated September 1, 1994, and destroy them.

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Unisys Corporation, fiscal agent for the Iowa Department of Human Services.

IOWA DEPARTMENT OF HUMAN SERVICES
Charles M. Palmer, Director

Donald W. Herman, Administrator
DIVISION OF MEDICAL SERVICES



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-92

Employees' Manual, Title 8
Medicaid Appendix

December 21, 1998

COMMUNITY MENTAL HEALTH CENTER MANUAL TRANSMITTAL NO. 98-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: *Community Mental Health Center Manual*, Table of Contents (pages 4 and 5), revised; Chapter F, *Billing and Payment*, pages 1 through 28, revised.

Chapter F is revised to update billing and payment instructions.

Date Effective

Upon receipt.

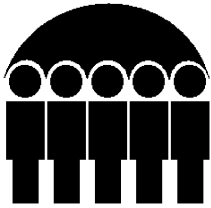
Material Superseded

Remove the following pages from the *Community Mental Health Center Manual* and destroy them:

| <u>Page</u> | <u>Date</u> |
|-------------------|-------------------|
| Contents (page 4) | September 1, 1994 |
| Contents (page 5) | March 1, 1996 |
| Chapter F | |
| 1, 2 | June 1, 1993 |
| 3, 4 | 12/90 |
| 5-14 | June 1, 1993 |
| 15 | Undated |
| 16-18 | 03/19/93 |
| 19-32 | June 1, 1993 |

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-212

Employees' Manual, Title 8

Medicaid Appendix

May 14, 2003

COMMUNITY MENTAL HEALTH CENTER MANUAL TRANSMITTAL NO. 03-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***COMMUNITY MENTAL HEALTH CENTER MANUAL***, Table of Contents, page 4, revised; Chapter E, *Coverage and Limitations*, pages 1 and 2, revised; Chapter F, *Billing and Payment*, page 16, revised; and pages 29 through 33, new.

Summary

The revisions to Chapter E are being made to agree with changes made to 441 Iowa Administrative Code 78.16(1)“b,” 78.16(2), and 78.16(3). Changes to these rules were made consistent with 2002 Iowa Acts, Chapter 1120, section 13. These revisions address the following:

- ◆ Under the heading “Centers Eligible to Participate,” the reference to “Division of Mental Health, Mental Retardation, and Developmental Disabilities” is replaced with this division’s current title of “Division of Behavioral, Developmental and Protective Services for Families, Adults and Children (BDPS).”
- ◆ Under the subheading “Conditions of Payment”:
 - Changes to paragraph 1 replace the requirement that CMHCs conduct an initial patient staffing by a psychiatrist with an initial staffing by a mental health professional, as defined under Iowa Code Section 228.1, with a referral to a psychiatrist if needed.
 - Changes to paragraph 2 replace the requirement for a four-week staffing to occur involving a psychiatrist with ongoing reviews that are part of the CMHC’s peer review process.
 - Changes to paragraph 3 replace the requirement for a four-month staffing involving a psychiatrist with ongoing reviews conducted by appropriate staff, as required by the CMHC’s peer review process, and evaluation and revision of the patient’s treatment plan as necessary.
 - Changes to paragraph 4 replace references to the four-week and four-month patient staffings with ongoing reviews under the CMHC’s peer review process, relative to such reviews not being separately payable services under Iowa Medicaid. However, the requirement under this paragraph that these reviews must be documented and are subject to review by the Department is retained.

The revisions to Chapter F:

- ◆ Add form 470-3744, *Provider Inquiry*. Complete this form if you wish to inquire about a denied claim or if claim payment was not as expected.
- ◆ Add form 470-0040, *Credit/Adjustment Request*. Complete this form to notify ACS that.
 - A paid claim amount needs to be changed; or
 - Funds need to be credited back; or
 - An entire *Remittance Advice* should be canceled.
- ◆ Change references from “Consultec” to “ACS.”

Date Effective

February 1, 2003

Material Superseded

Remove the following pages from ***COMMUNITY MENTAL HEALTH CENTER MANUAL*** and destroy them:

| <u>Page</u> | <u>Date</u> |
|----------------------------|------------------|
| Table of Contents (page 4) | December 1, 1998 |
| Chapter E | |
| 1, 2 | June 1, 1993 |
| Chapter F | |
| 16 | December 1, 1998 |

Additional Information

The updated provider manual containing the revised pages can be found at:

www.dhs.state.ia.us/policyanalysis

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

ACS
Manual Transmittal Requests
PO Box 14422
Des Moines, IA 50306-3422

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to ACS, fiscal agent for the Department of Human Services.